ROBERT H. OLIVER, M.D., PLLC
Otolaryngology – Head And Neck Surgery
Otolaryngic Allergy

Chart #_____

PATIENT INFORMATION
Please Print, Complete Fully, And Return To The Front Desk

Circle One: Mr. Mrs. Ms. Miss. Dr. Child

Please Circle: Sex: Male Female Marital Status: S M Other Widowed

Patient Legal Name: _____ Date of Birth: ___/___/____
First Middle Last

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email Address: _____

Name of Spouse/Parent/Legal Guardian: _____

Authorization to Treat Minor Child: _____

Relationship To Child: _____

In Case Of An Emergency We Ask That You Please Provide A Person To Notify:

Name: _____ Relationship: _____

Phone #: _____

Referring Physician: _____
Name Phone

Family Doctor: _____
Name Phone

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INSURANCE INFORMATION
Please Circle The Following Insurance Plan By Which You Are Covered

Chart #_____

First Insurance Name: Excellus MVP Aetna Cigna Fidelis

United HealthCare WellCare Essence Medicare Medicaid

Subscriber I.D. : _____

Insurance in the name of : _____ **DOB:**___/___/_____

Second Insurance Name: Excellus MVP Aetna Cigna Fidelis

UnitedHealthCare WellCare Essence Medicare Medicaid

Subscriber I.D. :_____

Insurance in the name of:_____ **DOB:**___/___/_____

Robert H. Oliver, M.D.
Otolaryngology & Otolaryngic Allergy
1295 Portland Avenue, Suite 24
Rochester, NY 14621
585-342-2080

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at the time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of my medical benefits to Robert H. Oliver MD PLLC on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize Robert H. Oliver MD PLLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. **MEDICARE REQUEST FOR PAYMENT**

Robert H. Oliver MD PLLC is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% coinsurance. Medicare or secondary carriers do not cover some procedures. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the copayment/coinsurance, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan, EXCEPT Medicaid, as a courtesy to you, so long as you provide all necessary policy information.

5. **Medicaid**

Robert H. Oliver MD PLLC does not participate with Medicaid. You will be responsible for the full/entire balance of your account.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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AUTHORIZATIONS: PART I

I authorize the release of medical records necessary to process insurance claims.
I am ***responsible*** to pay for all services received regardless of insurance coverage.
I authorize payment of medical and surgical benefits to be made directly to Dr. Robert H. Oliver M.D.
I authorize the release of correspondence and/or medical records to other providers involved in my care.
I authorize any holder of medical information about me to release records to Dr. Robert H. Oliver M.D.

Patient Signature:_____Date:____/____/____

AUTHORIZATIONS: PART II

HIPPA PRIVACY NOTICE

This practice is obligated under HIPPA to protect the privacy of your protected health information (PHI) and provide you with a notice of it's privacy practice.

ACKNOWLEDGMENT OF RECIPT: I acknowledge that I have reviewed a copy of the Practice's Privacy Notice. This notice describes the use of my healthcare information, discloses my protected health information and certain restrictions on the use of my health care information. I understand the Practice's Privacy Notice and it's effective date of January 1st 2009.

Patients Name:_____ Today's Date :____/____/____

Patient Signature:_____

Release of Medical information to the following individuals:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Patient Questionnaire

Patient Name:_____ **DOB:**_____ **Chart #**_____

What is the reason for your visit today? _____

_____

How long have you had this problem?_____ **days/weeks/months/years**

Please List:
Allergies to Medications/Food/Latex:_____

_____

_____

Current Medications (Name, Dosage, Frequency):

_____ _____

_____ _____

_____ _____

_____ _____

Current Pharmacy:
Name of Pharmacy:_____
Location:_____
Phone Number:_____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____Date:___/__/_____

_____Date:___/__/_____

_____Date:___/__/_____

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Chart# _____

Family History

Has anyone in your **family** (mother, father, siblings, grandparents) had:

☐ Anesthesia Problems	☐ Heart Disease	☐ Tuberculosis
☐ Anemia	☐ Hereditary Disease	☐ HIV (Aids)
☐ Arthritis	☐ High Blood Pressure	☐ Thyroid Problems
☐ Asthma	☐ Kidney Disease	☐ Diabetes
☐ Bleeding Disorder	☐ Mental Illness	☐ Stroke

Cancer (type): _____ **Other:** _____

Patient's Social History

Do You:
Use Tobacco (circle: Cigarettes/Cigars/Pipe/Snuff/Chew)
How Much Daily: _____(packs) For how many years:_____ Quit Date: ___/___/_____
Do You:
Use Alcohol (circle: Beer/Wine/Liquor)
How Often:_____ per day/month
Do You:
Use Drugs (circle: YES NO)
How Often:_____per day/month

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Patient's General Overall Health Review Part II

Please check all that apply to YOU: Chart#_____

General:
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Night Sweats
- ☐ Diabetes

Ears:
- ☐ Hearing Loss
- ☐ Pain
- ☐ Ringing
- ☐ Dizziness
- ☐ Frequent Infection

Nose:
- ☐ Bleeding
- ☐ Congestion
- ☐ Post-Nasal Drip
- ☐ Loss of Smell/Taste
- ☐ Injury

Throat:
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Pain

Eyes:
- ☐ Vision Change
- ☐ Cataracts
- ☐ Glaucoma

Heart:
- ☐ Chest Pain
- ☐ Valve Repair
- ☐ Pacemaker/Defibrillator
- ☐ Heart Murmur

Lungs:
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Pneumonia

GI:
- ☐ Heart Burn
- ☐ Stomach Ulcers
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver Problems

GU:
- ☐ Painful/burning During urination
- ☐ Kidney Stones
- ☐ Blood in Urine

Muscle:
- ☐ Arthritis
- ☐ Weakness in Limbs
- ☐ Tingling Sensation
- ☐ Back Pain
- ☐ TMJ/Jaw

Neuro/Psych:
- ☐ Depression/Anxiety/Panic Attack
- ☐ Headaches
- ☐ Numbness

Endocrine:
- ☐ Menopause
- ☐ Pregnancy
- ☐ Hormone Replacement
- ☐ Diabetes

Blood:
- ☐ Excessive Bleeding
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Hemophilia
- ☐ HIV

Allergy:
- ☐ Itchy Eyes
- ☐ Runny Nose
- ☐ Hives
- ☐ Previous Allergy Testing

Cancer (Type):_____

Other:_____

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Please Circle YES OR NO For the Following Questions:

May we leave a message on your home phone answering machine?	Yes	No
May we call or leave a message at your place of employment?	Yes	No
May we discuss your Medical Condition with a selected family member?	Yes	No

If Yes, With Whom do you give your Permission: _____

Relationship to Patient: __ Spouse __ Child __ Partner __Other

Date: ____/____/____

Reviewed By: Dr. _____ **Date:** ____/____/____